 Patient's name:_____

THIS PAGE IS FOR BILLING INFORMATION. IT MUST BE FILLED OUT COMPLETELY. FAILURE TO DO SO CAN RESULT IN ALL BILLS BEING SENT DIRECTLY TO YOU FOR FULL PAYMENT. PLEASE PRESENT YOUR INSURANCE CARD OR YOUR MEDICAL COUPON TO THE RECEPTIONIST. A COPY MUST BE MADE IF WE ARE TO BILL SOMEONE OTHER THAN YOU.

MEDICARE

Medicare number_____ Effective date for type A:_____ Effective date for type B:_____

MEDICAID

Medicaid: PIC #:_____ Case #:_____ Healthy Options:_____

Do you **have** or do you **need** a written referral from your physician? Yes ❒ No ❒

Name of the referring physician:_____ Phone number: (_____) _____-_____

Address (include city, state & zip code):_____

PRIVATE INSURANCE

Insurance subscriber:_____ (what person's name is the insurance listed under?)

Subscriber's social security number:_____-_____-_____ Relationship to the patient:_____

Name of the insurance company:_____

Group number:_____ Policy identification number:_____

Insurance billing address:_____

Telephone number to call for pre-authorization for procedures or services: (_____) _____-_____

SECONDARY PRIVATE INSURANCE

Do you have a secondary insurance company? Yes ❒ No ❒

Number of dependents that you claim on your income taxes:_____ Gross monthly income of the entire family: $_____

Do you live in: Your own house ❒ Your own apartment ❒ A friend or family member's house or apartment, *temporarily* ❒
In transitional or emergency housing ❒ In a homeless shelter ❒ The streets ❒
Have you been homeless within the last year? Yes ❒ No ❒

IF YOU HAVE NO MEDICAL COVERAGE, YOU MAY BE ELIGIBLE FOR THE "LOW INCOME ALLOWANCE PROGRAM". IF YOU WISH TO BE CONSIDERED FOR THIS PROGRAM, PLEASE COMPLETE THE FOLLOWING:

Do you rent or own your own home? Rent ❒ Own ❒ How much do you pay each month? $_____

How long have you lived here? _____ What is the market value of your house? $_____

What is the name of your bank? _____ Which branch do you go to? _____

Checking account number:_____ Savings account number:_____

I certify that the above information is accurate to the best of my knowledge

_____ patient ❒ parent ❒ guardian ❒
(signature)

Date:_____

Witness:_____

Translator:_____

I hereby request and authorize that I or my child (as named above) receive any and all medical and dental health care services available from and deemed necessary by the medical/dental staff of the Seattle-King County Department of Public Health. These services may include but are not limited to such procedures as x-rays, blood studies, photographs and immunizations. Consent is specifically given for the care in the event that the above-named child presents him/herself for treatment in my absence. Consent is given for the release of test results from the above procedures by phone to myself.

Signature of patient or legally responsible person _____

Relationship of legally responsible person to patient or child listed:_____